EDITORIALS

The Veterans Health Administration: A Domestic Model for a National Health Care System?

Health care in the United States is once again emerging as a key issue in national debates leading up to the 2008 presidential election. The discussions reflect, in part, growing public unease about the current health care system, fueled by rising health care costs,[1] concerns about the quality of American health care, and the growing number of Americans without health insurance (approaching 45 million).[2] These concerns are further ignited by recent reports that put the American health care system in perspective vis-à-vis the rest of the world. For instance, the World Health Organization ranked the US health care system at number 37 among 191 nations.[3] The Commonwealth Fund recently ranked the US health care system next to last compared with United Kingdom, Canada, New Zealand, and Australia.[4] Even among insured patients, the quality and equity of health care delivered in the United States has been a subject of debate.[5] Public concern about the US health care system is starting to show up in public satisfaction ratings. Although most Americans receive medical care locally, patient surveys demonstrate low satisfaction rates with health care quality or access.[6]

VETERANS HEALTH ADMINISTRATION AS A MODEL

In the past, when the debate about health care reform in the United States arose and people looked for ideas on how to improve the system, the working national health care models that experts often looked to were based on the Canadian health care system or those implemented by other industrialized nations, such as the United Kingdom, France, or Germany. For the first time in the history of this debate, the Veterans Health Administration is emerging as a local (domestic) model for the US national health care system. This is especially intriguing given that, only a decade or so ago, Veterans Affairs (VA) was viewed by many as a symbol of inefficient, poor-quality health care bureaucracy[7], in other words, what not to do in a health care reform.

Recent studies[8–11] on the performance of the VA compared with the private sector are starting to change attitudes toward the VA health care system. These studies indicate marked improvements in performance of the VA health care system compared with the market-based, private health care sector, which is increasingly seen as too costly and inadequate in quality performance. For example, diabetes care in the VA has been reported to be better than that of the private sector.[10] VA patients are reported to be more likely than even Medicare patients to receive life-saving treatments in cardiac care.[11] VA performance of many processes of care measures across a spectrum of health care services (screening, diagnostics, treatment, and follow-up) is better than in non-VA health care systems.[8] Patients receiving care within the VA report higher levels of satisfaction than do their counterparts receiving care in the private sector.[12]

The VA has emerged as the largest integrated health care system in the United States.[13] It was established in the 1930s as part of a national program for American war veterans. The true transformation of the VA health care system, however, was not set in motion until the passage of the Veterans Health Care Eligibility Reform Act of 1996. As part of this initiative, the VA sought to reinvent itself by undergoing major structural and management reorganization, which resulted in its emergence as a national leader in health care within a decade.[14,15] What is even more remarkable is that these achievements occurred at a time when the VA patient population was expanding. The number of VA patients accessing the system each year went up markedly from 2.5 million in 1995 to 5.3 million in 2005.[16]

It is not easy to pinpoint the factors that underlie the impressive transformation of the VA. This is in part because the broad reorganization of the VA was not designed to prospectively measure the impact of specific aspects of the reconstruction. However, an informed observation of the current VA health care system would note several unique elements that distinguish the VA from the private sector American health care system: (1) a centralized health care administration, (2) an emphasis on preventive (primary) care as the foundation of the system, (3) an automated health information system that includes a national electronic patient record system, and (4) an affordable, evidence-based medication prescription (pharmacy) plan. These are qualities that are clearly lacking in most American market-based private

health care systems. The remarkable thing is that the VA system has achieved these quality transformations while maintaining its traditional health care safety net role. Compared with the private sector population, the VA patient population has a disproportionately lower income and is older, sicker, and more likely to suffer from mental and behavioral illness. Veterans with disabilities that result from war-related trauma often seek medical care from the VA. Furthermore, in its formal affiliations with over 100 academic medical centers in 50 states and the District of Columbia, the VA continues to play an important role in educating future generations of health care providers.

THIS ISSUE OF THE JOURNAL

The VA may have outperformed itself in the past decade, but it is not time to become complacent. The collection of research articles and editorials featured in this theme issue articulate not only some recent VA health care successes but also some of the challenges the system still faces before it can be considered a worthy model for an eventual American national health care system. Starting with the challenges, Bartley et al. examined the VA psychiatric disability and rehabilitation policies for combat-related posttraumatic stress disorder and found the VA to be antiquated and in need of reforms to bring it in line with modern demands and scientific evidence in the management of posttraumatic stress disorder. Himmelstein et al. report that access to care within the VA is limited to veterans with service-connected health problems and low socioeconomic status. This leaves a large number of veterans with health care access problems unable to receive care at VA medical centers. For example, they found about 1.8 million uninsured veterans who were not receiving VA health care in 2004. Helmer et al. also report in this issue that, many years after the Persian Gulf War, veterans of that war continue to seek emergency department services for problems related to that war, suggesting that the health care needs of those veterans may not have been fully met.

On the positive side, Kimerling et al. report in this issue on the VA's unique, organized, and comprehensive response to military sexual trauma. They suggest that the universal screening policies implemented by the VA are feasible and provide clinically useful information to help patients cope with the mental health consequences of military sexual trauma, such as rape or sexual harassment. Jha et al. report further evidence showing improved VA performance in delivery of preventive health services, such as influenza and pneumonia vaccination rates, as part of its performance measurement program, whereas Keyhani et al. report that, compared with Medicare Fee-for-Service or Medicare HMO plans, VA health care was associated with increased uptake and utilization of preventive care services. Owens et al. found that there is sufficient prevalence of undocumented HIV infection to make it cost effective to implement routine voluntary screening in the VA system.

Lastly, two reports in this issue of the Journal provide suggestions for the VA to consider in improving quality of care for veterans. Weeks et al. evaluated older veterans' private sector utilization for 14 surgical procedures. They provocatively suggest in their report that directing older veterans with dual access (private and VA insurance) to high-volume and presumably high-quality private sector surgical care programs might save more lives than attempts to improve surgical care within the VA system. Yano et al. examined the role of primary care delivery in the reported quality transformation of the VA health care system over the past decade. They found that the provision of primary care may have significantly contributed to this gain. This is a strong argument for the role of primary care in any national health care system.

The improvements in structural organization and quality performance have resulted in the VA's emergence as a serious player in the American health care sector. Elements of the VA, such as centralized administration, emphasis on primary care, electronic medical records, and the provision of an affordable, evidence-based medication prescription plan, provide models to consider in any discussion on the merits and feasibility of a national health care system. However, as suggested by some of the studies featured in this issue on health care for veterans, the reported successes of the VA system are certainly not without ongoing challenges. ■

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References

1. Donelan K, Blendon RJ, Schoen C, Davis K, Binns K. The cost of health system change: public discontent in five nations. *Health Aff (Millwood).* 1999;18:206–216.

2. *Health Insurance Coverage and the Uninsured 1990–1998.* Washington, DC: Health Insurance Association of America; 1999.

3. *The World Health Report 2000—Health Systems: Improving Performance.* Geneva, Switzerland: World Health Organization; 2000.

4. Davis K, Schoen C, Schoenbaum SC, et al. *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care.* New York, NY: The Commonwealth Fund; 2007.

5. Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academies Press; 2003.

6. Blendon RJ, Schoen C, DesRoches CM, Osborn R, Scoles KL, Zapert K. Inequities in health care: a five-country survey. *Health Aff.* 2002;21:182–191.

7. Olilver A. The Veterans Health Administration: an American success story? *Milbank Q.* 2007;85:5–35.

8. Asch SM, McGlynn EA, Hogan MM, et al. Comparison for quality of care for patients in the Veterans Health Administration and patients in a national sample. *Ann Intern Med.* 2004;141:938–945.

9. Jha AK, Perlin JB, Kizer KW, Dudley RA. Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. *N Engl J Med.* 2003;348:2218–2227.

10. Kerr EA, Gerzoff RB, Krein SL, et al. Diabetes care quality in the Veterans Affairs Health Care System and commercial managed care. *Ann Intern Med.* 2004;141:272–281.

11. Peterson LA, Normand SL, Leape LL, McNeil BJ. Comparison of use of medications after acute myocardial infarc-

tion in the Veterans Health Administration and Medicare. *Circulation.* 2001; 104:2898–2904.

12. University of Michigan School of Business. American Customer Satisfaction Index, 2000–2006. Available at: http://www.theacsi.org/index.php?option=com_content&task=view&id=27&Itemid=62. Accessed August 24, 2007.

13. Evans L. *Recognizing the 75th Anniversary of the Establishment of the Veterans Administration.* Washington, DC: US Government Printing Office; 2005.

14. Kizer KW, Demakis JG, Feussner JR. Reinventing VA health care: systematizing quality improvement and quality innovation. *Med Care.* 2000;38:I7–I16.

15. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press; 2001.

16. Perlin JB. *Transformational Strategies of the U.S. Veterans Health Administration.* London, England: Health Foundation, International Health Care Quality Exchange Conference; 2005.